Diagnostic and management dilemma in a case of a huge broad ligament fibroid with retroviral disease

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INTRODUCTION

Fibroids are the most common uterine tumours. They have a very diverse disease spectrum with a complexity that is indefinite with extreme variation in terms of size, number and patient complaints. Extrauterine sites of fibroids are known to occur but are extremely rare. Because of its rare occurrence it poses a diagnostic dilemma and management. What might otherwise be a simple disease to treat may sometimes be extremely complex.

We are presenting one such case report where a diagnosis was doubtful. Only after opening the abdomen, it turned out to be a very huge broad ligament fibroid causing complete torsion of uterus with a stormy post-operative course in a patient with retroviral disease.

CASE REPORT

A 44 year old patient, para 4 living 4, known case of retroviral disease (sero concordant couple) since 7 years on anti-retroviral therapy, came to us with complaints of distension of abdomen, pain in abdomen and weight loss since 4 months. She had no menstrual complaints. On examination findings were consistent with diagnosis of an ovarian neoplasm. Possibility of a giant fibroid with cystic degeneration was distant. Complete haemostasis doesnot always gurantee post-operative haemorrhage. Hence putting a drain in abdomen and observation of vitals is important. Sometimes we believe that a prophylactic internal iliac ligation in cases of huge fibroids may avoid such complications.
right adnexae with multiple cystic areas, suggestive of an ovarian neoplasm.

Intra-operatively a huge pelvic mass was found extending upto liver superiorly and spleen on the left side. The mass was adherent at many places to the abdominal wall and intestines. Adhesions present were separated. The origin of the mass was traced to the right broad ligament. Whole of the uterus had undergone torsion. Impression was a huge degenerated broad ligament fibroid. Mass was delivered and total abdominal hysterectomy with bilateral salpingo-oopherectomy followed by appendicectomy (for enlarged inflamed appendix) was done. Haemostasis was doubly checked and abdomen was closed with a drain in situ.

Post operatively after 4 hours patient had tachycardia and blood pressure started falling and abdominal girth stated increasing although the drain did not show any increase in output. When the blood pressure did not increase even after 2 pints of blood transfusion, decision was taken to re-explore the patient. On re-exploring, a haemoperitoneum of 750 ml was found with retro peritoneal clot of size 15x12x10 cm ~ 750 ml. No active bleeding was noted from any pedicle. All pedicles were tied again followed by bilateral internal iliac ligation. Bleeding was noted from any pedicle. Haemostasis was doubly checked and abdomen was closed with a drain in situ.

DISCUSSION

Fibroid or leiomyoma is the commonest of all uterine tumours. They are common in child bearing age group. They are classified as subserous, interstitial, and submucous depending on their origin. Submucous fibroids arise beneath the endometrial layer and often project into endometrial cavity, interstitial or intramural fibroids arise within the myometrium, and subserous fibroids arise from serosal layer and present as adnexal masses. Extra-uterine fibroids are uncommon. Extra-uterine fibroids develop due to existence of smooth muscle at other sites, but broad ligament being the most common site. Common symptoms of fibroids include menstrual disturbances, dysmenorrhea, and pressure related symptoms (urological and gastrointestinal). Women with fibroids may experience recurrent pregnancy loss, decreased fertility, chronic pelvic pain and sizeable pelvic masses. These symptoms are neither mutually inclusive nor exclusive and cause significant disruption to patients well-being and quality of life. 30-50% patients become symptomatic and out of these many experience significantly elevated levels of distress and lower health related quality of life. Degenerative changes in the leiomyomas are due to inadequate blood supply and degenerative changes seem to depend on the degree and rapidity of the onset of vascular insufficient changes are the commonest form of degeneration. Cystic degeneration occurs in 4% of cases as a sequale of edema.

In this case the examination findings and CT scan findings were consistent with diagnosis of an ovarian neoplasm. Possibility of a giant fibroid with cystic degeneration was distant. The diagnosis was confirmed on histopathological examination.

CONCLUSION

Epidemiologists, demographers and clinicians are beginning to provide a clear picture of the true cost on the society due to uterine fibroids. Approximately 200000 hysterectomies and 30000 myomectomies are performed every year in the U.S. alone. These patients also require frequent OPD visits, hospitalisation, medications for symptom control, absence from work, psychological disturbances. Although fibroids are benign tumours they can grow to enormous size and often be mistaken as ovarian neoplasms. Although surgery can be done safely in experienced hands, sometimes when the anatomy is completely distorted, operative complications are unavoidable. Blood loss during surgeries can be decreased by preoperative GnRh analogues, uterine artery embolization, etc. and treated with blood and blood product transfusion. Complete haemostasis does not always guarantee post-operative haemorrhage. Hence putting a drain in abdomen and observation of vitals is important. Sometimes we believe that a prophylactic internal iliac ligation in cases of huge fibroids may avoid such complications.
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